

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/03/2011
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION ANI			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During self reported complaint #27372 conducted on May 3, 2011 no deficiencies were cited under State Licensure 1200-3-6 Standards for Long Term Care.		N 002		